WORKERS' COMPENSATION CLAIM PACKAGE FOR REPORTING ON-THE-JOB INJURIES/ILLNESSES

All State Civil Service (SCS) and State Active Duty (SAD) employees are covered by the Workers' Compensation system. It provides compensation when employees are unable to work because of a job-related disability. The cost of this protection is completely paid by the State of California and the employee makes no contribution. Benefits are tax-free and not subject to social security deductions.

Managers and supervisors are responsible for the welfare of employees and for reporting a job related injury/illness in a timely manner. The law requires each employer to provide a safe place of employment; however injuries may still occur. Your employees should be instructed to report any and all incidents as soon as possible.

Managers and supervisors must ensure that employees receive prompt medical treatment by the nearest doctor or emergency room, if such care is believed to be necessary. For injuries requiring immediate emergency assistance, dial 911. The employee should report to the medical office that he was injured on-the-job. If the employee is not able to return to work immediately, have the employee find out how long he/she will be off work.

INCLUDED IN THIS PACKAGE ARE THE FOLLOWING ITEMS:

[] SCIF 3067 - Employer's Report of Occupational Injury or Illness

[] Instructions for Completion of SCIF 3067

[] SCIF 3301 – Employee's Claim For Workers' Compensation Benefits

[] Instructions for Completion of SCIF 3301

AFTER COMPLETION OF THE SCIF 3067 AND SCIF 3301, PLEASE FAX THEM TO (916) 854-3647 AND MAIL THE HARD COPY TO:

STATE OF CALIFORNIA, MILITARY DEPARTMENT
ATTN: STATE PERSONNEL PROGRAMS, BOX 27
P.O. BOX 269101
SACRAMENTO, CA 95826-9101

YOU MAY CALL (916) 854-3680, IF YOU REQUIRE ASSISTANCE IN ANSWERING QUESTIONS OR COMPLETING THE FORMS.

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type, if possible). Mail original and one copy to:

STATE COMPENSATION INSURANCE FUND

Refer to STATE ADMINISTRATIVE MANUAL, SECTIONS 2581.2 – 2581.5 for instructions on completion and routing.

BOTH SIDES OF THIS FORM MUST BE COMPLETED

OSHA Case No. _____

☐ Fatality

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident ***OR*** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported **immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. DEPARTMENT: State of California, Military Department
1A. AGENCY CODE OR SCIF POLICY NUMBER
DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, City, ZIP): 9800 Goethe Road, P.O. Box 269101, Sacramento, CA 95826-9101
2A. PHONE NUMBER: (916) 854-3680
Case No.
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)
3A. DIV./LOCATION CODE
Ownership
4. NATURE OF BUSINESS: Governmental Agency
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
Industry
6. TYPE OF EMPLOYER
☐ PRIVATE ☒ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY _____
Occupation

EMPLOYEE

7. EMPLOYEE NAME
CSID#
8. SOCIAL SECURITY NUMBER
9. DATE OF BIRTH (mm/dd/yy)
Sex
10. HOME ADDRESS (Number and Street, City, ZIP)
10A. PHONE NUMBER
Age
11. SEX ☐ MALE ☐ FEMALE
12. OCCUPATION (Regular job title–No initials, abbreviations or numbers)
CBID#
13. DATE OF HIRE (mm/dd/yy)
Daily hours
14. EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours
14A. EMPLOYMENT STATUS (See instructions in 14A continued below.) ____ regular full-time ____ part-time ____ temporary ____ seasonal
14B. Under what class code of your policy were wages assigned?
Days per week
15. GROSS WAGES/SALARY $ _____ per _____
16. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $ _____ per _____ ☐ NO
Weekly hours

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm/dd/yy)
18. MILITARY TIME INJURY/ILLNESS OCCURRED
19. MILITARY TIME EMPLOYEE BEGAN WORK
20. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
Weekly wage
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
22. DATE LAST WORKED (mm/dd/yy)
23. DATE RETURNED TO WORK (mm/dd/yy)
24. IF STILL OFF WORK, CHECK THIS BOX ☐
County
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
26. SALARY BEING CONTINUED? ☐ YES ☐ NO
27. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)
28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm/dd/yy)
Nature of injury
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning.
Part of body
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
30A. COUNTY
30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
Source
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO
Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
Sec. Source
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes onto truck.
Extent of Injury
35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
37A. PHONE NUMBER
38. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ NO
39. PERS/STRS MEMBERS ☐ YES ☐ NO
40. ARE LEAVE CREDITS AVAILABLE TO BE USED IN SUPPLEMENTING INDUSTRIAL DISABILITY LEAVE BENEFITS? ☐ YES ☐ NO
14A. EMPLOYMENT STATUS CONT. (Check current status of employment, not status at time of injury.)
____UNEMPLOYED ____ON STRIKE ____DISABLED ____RETIRED ____LAID OFF ____OTHER

Completed by (type or print)	Signature	Title	Date

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE

If the Supervisor and Manager Review portions of this form cannot be completed within five days of the injury, DO NOT DELAY SUBMISSION OF THE REVERSE SIDE TO STATE FUND. Submit the form completed in its entirely to the Departmental Safety Coordinator within ten days of the injury.

EMPLOYEE'S NAME	UNIT	SOCIAL SECURITY NUMBER

SUPERVISOR'S REVIEW

Facts available lead me to believe this work injury was caused by and happened during State work. ☐	From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with State employment. ☐	The facts do not indicate this claim of injury was work connected. ☐

GIVE THE FACTS THAT JUSTIFY THE ITEMS CHECKED:

WHAT CORRECTIVE ACTION IS BEING TAKEN TO PREVENT SIMILAR ACCIDENTS? HAVE YOU TAKEN THESE STEPS? ☐ YES ☐ NO If no, explain.

I DO NOT HAVE AUTHORITY TO TAKE THE FOLLOWING ACTION BUT RECOMMEND:

IF INJURED EMPLOYEE IS UNABLE TO PERFORM FULL DUTY:

A. THE POSSIBILITY OF MODIFIED WORK WAS DISCUSSED WITH THE ATTENDING DOCTOR: ☐ YES ☐ NO

B. MODIFIED WORK DECISION: ☐ Condition precludes M.W. ☐ Appropriate M.W. not available ☐ M.W. arranged_____days

Signature	Classification	Date

MANAGER'S REVIEW

DO YOU CONCUR WITH FIRST LINE SUPERVISOR'S REVIEW? ☐ YES ☐ NO If no, explain.

Signature and Date

CONTINUATION AND MISCELLANEOUS COMMENTS:

STATE COMPENSATION INSURANCE FUND ADJUSTING OFFICES

P.O. Box 9729
Bakersfield, CA 93389-9729

P.O. Box 91-1112
Commerce, CA 90091-1112

P.O. Box 4973
Eureka, CA 95502-4973

P.O. Box 40000
Fresno, CA 93755-4000

P.O. Box 9045
Oxnard, CA 93031-9045

P.O. Box 496049
Redding, CA 96049-6049

P.O. Box 59901
Riverside, CA 92517-1901

P.O. Box 1609
Rohnert Park, CA 94927-1609

P.O. Box 659011
Sacramento, CA 95865-9011

P.O. Box 1316
San Bernardino, CA 92402-1316

P.O. Box 530957
San Jose, CA 95153-5357

INSTRUCTIONS FOR COMPLETION OF SCIF 3067

This form must be completed and signed by a supervisor or manager based on the initial investigation and sent to this office **WITHIN FIVE WORKING DAYS** OF INJURY/ILLNESS. **The injured/ill employee should not complete this form.**

Please note the abbreviations **SCS** and **SAD** stand for "State Civil Service" and "State Active Duty", respectively.

EMPLOYER SECTION

1. Enter: State of California, Military Department

1a. LEAVE BLANK

2. Enter: 9800 Goethe Road, P.O. Box 269101, Sacramento, CA 95826-9101

2a. Enter: (916) 854-3680

3. Enter employee's work site location

3a. LEAVE BLANK

4. LEAVE BLANK

5. LEAVE BLANK

6. Check "STATE" box

7. Enter employee's full name – DO NOT USE NICKNAMES

CSID# SCS-Enter position number
SAD-LEAVE BLANK

8. Enter Social Security number

9. Enter Date of Birth

10. Enter home address-Not a P.O. Box, to include city, state and zip code

10a. Enter phone number to include area code

11. Check either male or female

12. Enter SCS or SAD job title

CBID# SCS-Enter bargaining unit number SAD-LEAVE BLANK

13. Enter date hired

14. Enter normal work schedule hours

14a. Enter current employment status

14b. LEAVE BLANK

15. Enter monthly salary rate

16. LEAVE BLANK

17. Enter date incident occurred. If date is unknown, enter "UNKNOWN"

18. Enter military time incident occurred

19. Enter military time employee began work

20. LEAVE BLANK

21. Enter "YES" if there will be absences from work; enter "NO" if employee will immediately return to work

22. Enter date last worked

23. Enter date employee returned to work

24. Check this box if employee is still off work

25. Enter "YES"

26. Enter "YES"

27. Enter date incident was reported to supervisor

28. Enter date employee was provided ***SCIF 3301, EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS***

29. Indicate specific injury/illness and affected body part. Include left, right, upper or lower, etc. Examples: right ankle, left upper arm, middle back, jaw, stomach, throat, left wrist.

30. Enter address and location where incident occurred-Not a P.O. Box

30a. Enter county where incident occurred

30b. Check either "YES" or "NO"

31. Enter location where incident occurred. Examples: Elevator, hallway, kitchen, restroom, warehouse.

32. Check either "YES" or "NO"

33. Give specific information about the object or substance that directly injured the employee. Examples: Boxes, carpet, chair, computer, drawer, dust, ladder, steps, wall.

34. Describe what employee was doing when incident occurred

35. Describe the sequence of how incident occurred. Examples of activity: Bending, chemical, electrical shock, training, pulling/pushing.
Which resulted in: Dizziness, burn, cardiac, fracture.

36. Enter the name and address of physician. If employee was not seen, LEAVE BLANK.

36a. Provide phone number, if known

37. Complete if employee was hospitalized

37a. Provide phone number, if known

38. Check either "YES" or "NO"

39. Check "YES"

40. Check "YES"

Continuation of 14a. LEAVE BLANK

Completed by: Requires completion by supervisor or manager to include signature, title and date.

REVERSE SIDE OF SCIF 3067

--Enter employee's name, unit (same information as #4) and social security number.

SUPERVISORS REVIEW

--Check one of the 3 boxes.

--Complete with the facts that justify the item checked.

--Indicate what corrective action is being taken and if you have taken these steps.

--Leave Blank unless you as the supervisor do not have the authority to accomplish.

--LEAVE BLANK

--Complete with signature, classification and date.

MANAGERS REVIEW

--Check either "YES" or "NO"

--If "NO", explain

--Complete signature and date

--Continuation and miscellaneous comments

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Complete the **"Employee"** section and give the form to your employer. Keep the copy marked **"Employee's Temporary Receipt"** until you receive the dated copy from your employer. You may call the Division of Workers' Compensation at **1-800-736-7401** if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the back of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

PETICION DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

*Complete la sección **"Empleado"** y entregue la forma a su empleador. Quédese con la copia designada **"Recibo Temporal del Empleado"** hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, Ud. puede hablar con la Division de Compensación al Trabajador llamando al **1-800-736-7401.** En la parte de atrás de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee: *Empleado:*

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of injury. *Hora en que ocurrió* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado* _____
8. Signature of employee. *Firma del empleado.* _____

Employer - complete this section and give the employee a copy immediately as a receipt.
Empleador - complete esta sección y déle inmediatamente una copia al empleado como recibo.

9. Name of employer. *Nombre del empleador.* State of California, Military Department
10. Address. Dirección. 9800 Goethe Road, P.O. Box 269101, Sacramento, CA 95826-9101
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañia de seguros o agencia administradora de seguros.* **STATE COMPENSATION INSURANCE FUND** _____
15. Insurance Policy Number. *El número de la póliza del Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Date. *Fecha.* _____ 19. Telephone. *Telefono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

STATE COMPENSATION INSURANCE FUND

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañia de seguros, administrador de reclamos, o dependiente representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de **un dia hábil** desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

INSTRUCTIONS FOR COMPLETION OF SCIF 3301

Provide this form to the injured/ill employee **WITHIN ONE WORKING DAY** of knowledge of injury/illness.

The "Employee" section must be completed by the employee and the "Employer" section must be completed by the supervisor or manager. Include this form along with SCIF 3067 report to this office.

EMPLOYEE SECTION

1. Enter your name

--Enter today's date

2. Enter your home address-not a P.O. Box

3. Enter City, State and Zip Code

4. Enter date of injury/ illness

--Enter time of injury/illness, to include a.m. or p.m.

5. Enter the address and give a description of where the injury happened

6. Describe the injury/illness and part of body affected

7. Enter your social security number

8. Complete with your signature

PLEASE GIVE TO YOUR SUPERVISOR OR MANAGER FOR COMPLETION OF EMPLOYER'S SECTION

EMPLOYER'S SECTION

9. Enter: State of California, Military Department

10. Enter: 9800 Goethe Road, P.O. Box 269101, Sacramento, CA 95826-9101

11. Enter the date you first knew of injury/illness

12. Enter the date you provided this form to employee

13. Enter the date you received back from the employee

14. LEAVE BLANK

15. LEAVE BLANK

16. Complete with your signature

17. Complete with your title

18. Complete with today's date

19. Complete with your work telephone number to include area code